Filing at a Glance

Company: Standard Security Life Insurance Company of New York

Product Name: SSL EEAPP 0210 and ERAPP 0210	SERFF Tr Num: ICCI-126586603	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 45896
Sub-TOI: H16G.003A Small Group Only - PPO	Co Tr Num: SSL APP 0210	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Brenda Dawson	Disposition Date: 06/16/2010
	Date Submitted: 06/08/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: SSL EEAPP 0210 and ERAPP 0210	Status of Filing in Domicile:
Project Number: SSL EEAPP 0210 and ERAPP 0210	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small
Overall Rate Impact:	Group Market Type: Employer, Trust
Filing Status Changed: 06/16/2010	Explanation for Other Group Market Type:
	State Status Changed: 06/16/2010
Deemer Date:	Created By: Brenda Dawson
Submitted By: Brenda Dawson	Corresponding Filing Tracking Number:
PPACA: Pre-PPACA Submission	

Filing Description:

Enclosed for review and approval for use in your state are the forms attached to the Form Schedule tab. These forms are new and are not intended to replace any forms previously approved by your Department. These forms are intended to be used with Group Major Medical Expense Policy form SSL MMC 0205 previously approved by your Department on June 30, 2005.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Standard Security Life Insurance Company of

SERFF Tracking Number:	*ICCI-126586603*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45896*
Company Tracking Number:	*SSL APP 0210*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*SSL EEAPP 0210 and ERAPP 0210*		
Project Name/Number:	*SSL EEAPP 0210 and ERAPP 0210/SSL EEAPP 0210 and ERAPP 0210*		

New York. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at the address shown above.

These forms were revised to include some minor modifications.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

These documents were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the non-variable text of the forms or to the general print size.

Company and Contact

Filing Contact Information

Brenda Dawson, Authorized Representative	Brendadawson@inscompliance.com
3925 East State Street, Suite 200	815-316-6714 [Phone]
Rockford, IL 61108	815-986-2355 [FAX]

Filing Company Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Standard Security Life Insurance Company of New York	CoCode: 69078	State of Domicile: New York
485 Madison Avenue, 14th Floor	Group Code:	Company Type:
New York, NY 10022	Group Name:	State ID Number:
(212) 355-4141 ext. [Phone]	FEIN Number: 13-5679267	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	$50 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #

SERFF Tracking Number:	*ICCI-126586603*	*State:*	*Arkansas*
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Standard Security Life Insurance Company of New York	$100.00	06/08/2010	37061617

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/16/2010	06/16/2010

SERFF Tracking Number:	*ICCI-126586603*	*State:*	*Arkansas*
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Disposition

Disposition Date: 06/16/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ICCI-126586603*	*State:*	*Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	SSL Authorization Letter	Approved-Closed	Yes
Form	Employee Enrollment form	Approved-Closed	Yes
Form	Employer Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SSL EEAPP 0210

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/16/2010	SSL EEAPP AR 0210	Application/ Enrollment Form	Employee Enrollment form	Initial			AR SSL EEAPP AR 0210 6-8-10.pdf
Approved-Closed 06/16/2010	SSL ERAPP 0210	Application/ Enrollment Form	Employer Application	Initial			SSL ERAPP 0210 (For Filing) 041410.pdf

Standard Security Life Insurance Company of New York

Group Insurance

Employee Enrollment Form

Group Name: _____

❑ New group
❑ Addition to existing group
Group # _____

A. Employee Information

[Name (last, first, MI)	Social Security number	Marital status ❑ Single ❑ Married ❑ Domestic Partner

Home address	City	State	ZIP code

Telephone number	Best time for us to call ❑ a.m. ❑ p.m.	E-mail address

Date of full-time employment	Job title/occupation	Hours worked per week

Compensation basis	Employee status	Are you covered by workers' compensation?	Current status
❑ Salary ❑ Hourly ❑ Commission	❑ W2 ❑ 1099 ❑ Owner/partner	❑ Yes ❑ No	❑ Actively at work ❑ Other: _____ ❑ COBRA - termination date: _____]

B. Application Intentions

Coverage Type	Applying for coverage for: Myself/Employee	Spouse/ Domestic Partner	Children	Waiving coverage for: Myself/Employee	Spouse/ Domestic Partner	Children
Medical	❑	❑	❑	❑	❑	❑
[Life	❑	❑	❑	❑	❑	❑]
[Dental	❑	❑	❑	❑	❑	❑]
[Vision	❑	❑	❑	❑	❑	❑]

C. Applicant, Spouse/Domestic Partner and Dependent Children Information

Name (last, first, MI)	Social Security Number	Sex	Height	Weight	Relationship	Date of birth	[Tobacco use/] [Full-time student]
Myself/Employee		❑ M ❑ F			Employee		[❑ Non-tobacco ❑ Tobacco user]
		❑ M ❑ F			Spouse or Domestic Partner		[❑ Non-tobacco ❑ Tobacco user]
		❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other		[❑ Yes -FT student ❑ No]
		❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other		[❑ Yes -FT student ❑ No]
		❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other		[❑ Yes -FT student ❑ No]

Application Instructions:

- If you and all eligible dependents are applying for medical and/or life insurance coverage, complete all sections of the application except Section D, Request to Waiver Coverage. Be sure to sign and date at the bottom of Section J.
- If you and all dependents are waiving/declining coverage, complete Section D. Be sure to sign and date at the bottom of Section D.
- If you are applying for coverage but have eligible dependents waiving, complete all sections of the application.

Administrative Use Only	Timely EE	Spec Enroll	Late Enroll	24-hour cov	Life Amount	PCEFDT	[Pre-Ex Ends]	Eff Date	UW Apprvl	Part #	Entered by

D. Request to Waive Coverage

I, and/or my dependents, request to decline coverage because of:

	Other group coverage	Covered under individual medical	Covered under government-sponsored plan	COBRA coverage	Other	No coverage
Employee	❑	❑	❑	❑	❑	❑
Spouse or Domestic Partner	❑	❑	❑	❑	❑	❑
Child(ren)	❑	❑	❑	❑	❑	❑

If declining coverage due to other coverage, please list the name and phone number of the insurance company (or employer if covered through a self-funded plan) and policy number:

Name(s) of covered family members	Insurance company name, if known, or employer if self-funded	Primary insured and SSN	Policy number, if known

[This is to acknowledge I have been given the opportunity to apply for the available coverages and have elected not to enroll myself or my dependents, if any. I understand that by applying for coverage at a later date I may be considered a late applicant. If I am a late applicant, I will be subject to an [12][18]-month pre-existing exclusion limitation period. I acknowledge that I have not been persuaded to waive coverage by my employer or the producing agent.]

I understand that if I waive coverage for myself or my dependents because of being covered under other health insurance coverage, I may, in the future, be able to enroll myself or my dependents in this plan if the other health insurance coverage terminates. The other health coverages must have terminated because of either: 1) the "loss of eligibility" for coverage, or 2) the termination of the employer plan by the employer. I understand that I must apply for coverage within 30 days of a qualifying life event or termination of other coverage to be eligible for a special enrollment period. "Loss of eligibility" includes a loss of coverage due to legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment. Loss of eligibility does not include an individual's failure to pay premiums on a timely basis or in the event of termination of coverage for cause. Examples of a loss of coverage for cause include the making of a fraudulent claim or an intentional misrepresentation of fact in connection with a group health plan.

In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand I may be able to enroll myself and certain dependents, provided that I apply within 30 days after the marriage, 90 days after birth, and within 60 days of having filed a petition to adopt a minor.

X _____ _____

Signature of Employee *(if declining coverage)* Date

E. Health Questions

Please provide complete details to any question marked "Yes" in the appropriate space provided in section F.
We may need to request additional information regarding your health history from you and/or your attending physician.

1. Are you or any enrolling dependents receiving treatment for or have you been advised of a condition that will require medical attention or medical test(s)?	❑ Yes ❑ No
2. Are you or any enrolling dependents currently disabled, or confined to a hospital, medical facility or your home due to a medical condition or disability?	❑ Yes ❑ No
3. Have you or any applying dependents incurred medical expenses over [$10,000] in the last [12] months?	❑ Yes ❑ No
4. Are you or your enrolling dependents currently taking or have been prescribed medications within the past [12] months? *If yes, complete the medications chart below.*	❑ Yes ❑ No

Person's name	Medication	Dosage and Frequency	Date started & Date ended	Condition	Complete names and addresses of physicians

5. Does any person to be insured currently have or had within the <u>past [five] years</u> symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for any disorder or disease of the following: (*Remember to provide details to any "Yes" answers in Section F - Health History Details)*

Circulatory System	a. Abnormal heart beat/palpitations, blood disorder/hemophilia, hypertension, chest pain, heart disease/murmur/heart attack or coronary artery disease, lymphadenopathy/immune disorder, stroke, vascular disease	❑ Yes ❑ No
	b. High blood pressure, high cholesterol or high triglycerides *(If yes, please provide the most recent readings and date)* Blood pressure reading: _____/_____ Cholesterol reading: _____ Triglyceride reading: _____ Date : _____ Date: _____ Date: _____	❑ Yes ❑ No
Cyst, Polyp, Tumor	c. Cancer, tumors/cysts/polyps/growths	❑ Yes ❑ No
Endocrine Disorders	d. Diabetes/pancreatic disorders, thyroid, goiter	❑ Yes ❑ No
Gastrointestinal Disorders	e. Colitis, hepatic, spastic colon, polyps, digestive disorder/reflux, gallbladder disorder, hernia, ulcerative colitis, Crohn's/regional ileitis, ulcers, Hepatitis (A, B, or C), liver disorder	❑ Yes ❑ No
Genitourinary Disorders	f. Abnormal Pap smear, breast disorder, infertility testing/treatment, menstrual disorder, reproductive organ disorder, endometriosis, sexually transmitted diseases, Acquired Immune Deficiency Syndrome (AIDS), bladder disorder, kidney disorder, prostate/rectal disorder	❑ Yes ❑ No
	g. Current pregnancy *If yes, please provide the expected due date*_____	❑ Yes ❑ No
Nervous Disorders	h. Anorexia/bulimia, mental, nervous, emotional disorder/anxiety, depression/attention deficit disorder, mental retardation/Down syndrome, neurological disease, sleep disorders	❑ Yes ❑ No
	i. Epilepsy and/or seizure, headaches/migraines, muscular dystrophy, cerebral palsy, neurological disease, paralysis	❑ Yes ❑ No
Other Disorders	j. Abnormal tests results, alcoholism/alcohol abuse, drug addiction, ear/throat disorders, eye disorders, transplants	❑ Yes ❑ No
Respiratory Disorders	k. Allergies, asthma/respiratory disorder, cystic fibrosis, emphysema/lung disorder, sleep apnea, sinus disorder, tuberculosis If "yes" for sleep apnea and treatment is through a CPAP machine, do you rent or own the machine? ❑ Rent ❑ Own	❑ Yes ❑ No
Skeletal/Muscular Disorders	l. Arthritis, back/muscle/joint disorder, bone disease/deformity, congenital disorder, fracture/dislocation, Lupus/systemic or discoid, rheumatism, skin disorder, spinal disorder, back/neck strain	❑ Yes ❑ No

F. Health History Details, *(details required for "Yes" answers in Section E).*

Ques. #	Person's name	Condition and treatment	Date of onset Mo/Yr	Recovery date Mo/Yr	Complete name and address of physicians and hospitals

G. Prior Insurance Coverage Information

1. Have you and all dependents enrolling been covered by this employer's **major medical** plan for the past 12 months?	❑ Yes ❑ No
2. Have you and all dependents enrolling been covered under a **major medical** plan with another carrier(s) other than your current employer coverage within the past 12 months? *If "Yes", attach a copy of the certification of group health insurance plan coverage or other documentation of creditable coverage AND complete the following:*	❑ Yes ❑ No

Name(s) of covered family member	Effective date	Termination date (if applicable)	*Type of Coverage*				
			Employer group coverage	Individual medical	Government-sponsored plan	COBRA	Other
			❑	❑	❑	❑	❑
			❑	❑	❑	❑	❑

Prior medical carrier company name, phone number and policy number

[3. If applying for dental coverage, do you currently have employer group dental coverage? ❑ Yes ❑ No *If "Yes", was coverage for orthodontia included?* ❑ Yes ❑ No	Prior dental carrier company name, phone number and policy number]

H. Life Insurance Beneficiary

[Beneficiary name	Relationship]

I. Preferred Provider Network

Network selected

J. Agreement and Signature

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
[Arkansas Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]
[Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]
[New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]
[Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]
[Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.]
[Virginia Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[This group health plan contains a pre-existing condition exclusion period of [12] months [([18] months for late enrollees)]. This exclusion period can be reduced by the number of days you maintained prior creditable coverage. When applying creditable coverage to the pre-existing condition limitation, the plan will not take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any pre-existing condition limitation will apply to you, you must submit a certificate of creditable coverage. Creditable coverage can include coverage under another group health plan, an individual medical health policy, short-term health plans, student health plans, Medicare, Medicaid, TriCare (formally CHAMPUS), a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, a health plan issued under the Peace Corp Act or an S-CHIP. You may request a certificate of creditable coverage from a previous employer's insurance company or Health Maintenance Organization (HMO). If you submit a certificate of creditable coverage (or documentation of creditable coverage through other means) then we will make a determination regarding the length of any pre-existing condition exclusion that applies to you or your dependents. If you cannot obtain a copy of your certificate of creditable coverage, you may contact the plan administrator for assistance. We reserve the right to modify an initial determination of creditable coverage if we determine that your claimed coverage is in error, provided that we send you a notice of reconsideration. Until the final determination is made, we will, for the purpose of pre-certification under the plan, act in a manner consistent with the initial determination. If applying for dental insurance, employees who are covered under their employers group dental plan on the date immediately prior to the effective date of coverage on this plan will be given credit for the satisfaction of any calendar year deductible amounts and waiting periods under the new dental plan.]

Premium Payment: I authorize my employer to deduct the requested premium contribution, if any, from my earnings.
Full-Time Employment: I understand that one of the requirements for eligibility on the effective date and for continued eligibility under the plan is that I am actively at work and employed full-time (at least [30] hours per week) at my employer's place of business.
Pre-certification: I understand that failure to pre-certify treatment results in reduced benefits pursuant to the terms of the group master policy.
Benefit Availability: I understand that my benefits under this plan begin with a specific effective date of coverage applicable to me and coverage ends at the end of a month in which due premium has not been paid. I understand if I attempt to utilize the benefit plan or prescription drug card when coverage is no longer effective under the plan, I will be personally responsible for those expenses incurred and can be billed by the providers or insurance company for those services.
U.S. Resident: I understand that the coverage under this plan is available for United States residents and benefits are not payable for medical expenses outside of the United States except for emergency care when traveling.
Pre-existing condition limitation provisions: I understand that my coverage and that of my dependents, if approved, may be subject to pre-existing conditions limitation provisions regardless of the medical conditions disclosed on the application pursuant to the terms of the group master policy.
My answers are true and correct: I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all questions asked. I understand that any intentional material misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my dependents. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any questions; or instruct me not to disclose any particular medical condition on the Application. I understand that no agent is authorized or has authority to alter the terms of the group master policy.
Application for Group: I understand that my employer agreed to participate in the group to which the group policy was issued, and I am simultaneously applying for insurance for which I am now or may be eligible for under the provisions of the group policy issued to that group by Standard Security Life Insurance Company of New York, I understand that my insurance will not be inforce until the application is approved by Standard Security Life Insurance Company of New York, or their authorized administrator in accordance with the underwriting guidelines in effect.

X_____ _____

Signature of Employee *(and parent if applicant is under age 18)* Date

Standard Security Life Insurance Company of New York

Group Insurance

Employer Application

[Requested effective date: _____]

A. Employer Information

Legal name of company	DBA
Type of company ❑ LLC ❑ S-Corporation ❑ Non-profit ❑ Other: _____	
Street address (no PO box)	City
County	State / ZIP code
Billing address (if different than street address)	City / State / ZIP code
Contact (must be an employee at the company)	Telephone number / Fax number
Contact e-mail address	Owner or proprietor
Nature of business / SIC	Federal tax ID number / Number of years in business

B. Employers with Multiple Locations

If employees of any affiliated business organizations or separate locations are to be covered, please list the affiliate or location(s) below.

Affiliate name/address	Nature of business	Business relationship	Tax ID	Number of employees:
1.				Full-time: _____ Part-time: _____
2.				Full-time: _____ Part-time: _____

C. Waiting Period and Effective Date Provisions

Select a waiting period (Effective 1st of the month following) :

[❑ 30 days ❑ 60 days ❑ 90 days ❑ Other _____ (Subject to underwriting approval) *(The waiting period may be changed only at renewal.)*]

The waiting period selected will apply to:

[❑ Employees hired after the effective date ❑ All current and future employees]

D. Prior Coverage Information

Will this plan replace other group medical coverage?	❑ Yes ❑ No

If yes, please provide [12] months of information below and attach a copy of the most recent billing.

Prior medical carrier	Policy number	Effective date (mm/dd/yyyy)	Termination date (mm/dd/yyyy)	Major medical plan?
				❑ Yes ❑ No
				❑ Yes ❑ No

D. Prior Coverage Information *(Continued)*

[Will this plan replace other group dental coverage?	❑ Yes ❑ No

If Yes, please provide [12] months of information below and attach a copy of the most recent billing.

Prior dental carrier	Policy number	Effective date (mm/dd/yyyy)	Termination date (mm/dd/yyyy)	Orthodontia coverage included?
				❑ Yes ❑ No
				❑ Yes ❑ No]

E. Continuation/COBRA

1. Are any employees or dependents currently on COBRA or other continuation of coverage? If yes, list the individuals:	❑ Yes ❑ No
2. Are any employees or dependents currently in an election period for COBRA or other continuation? If yes, list the individuals:	❑ Yes ❑ No

Please note, an Application form and a copy of the COBRA election form must be submitted for each person to be covered under your group plan through COBRA.

F. Eligibility

Are any employees currently absent due to illness or injury, family medical leave or receiving disability benefits? If yes, provide names and details:	❑ Yes ❑ No

G. Employer Contribution

❑ Defined Contribution Amount

$_____ per employee per month $_____ per employee with dependents per month

❑ Percentage of Premium Contribution

_____ % of employee health premium and _____ % of dependent health premium

_____ % of employee dental premium and _____ % of dependent dental premium

H. Employee Participation

Total number of full-time employees	Total number of part-time employees
Total number of employees	Total number of full-time employees applying for medical coverage

All eligible employees are expected to apply for coverage during the employer's initial enrollment period, including those who may not be eligible for coverage yet because they are still in their waiting period. As indicated earlier in the application, the employer may waive the waiting period at initial enrollment to maximize employee participation. Groups must meet the following participation guidelines at enrollment and stay above participation minimums while covered by the plan. For all size groups, 50 percent of full-time eligible employees must enroll, regardless of employees waiving due to other coverage.

Group size	Minimum required employee participation	Minimum required dependent participation - no maternity coverage	Minimum required dependent participation - with maternity coverage
[2 - 4] employees	[100]%	[50]%	[50%] [Plan not available]
[5 - 9] employees	[75]%	[50]%	[75]%
[10] or more employees	[75]%	[No requirement]	[No requirement]

I. Acknowledgements

The employer hereby applies for coverage under the Group Master Policies ("policy") issued to [Multiple Unit Security Trust ("trust")] by Standard Security Life Insurance Company of New York ("Insurer"). The employer hereby joins the trust for the purpose of establishing an employee welfare benefit plan. Employer agrees that the insurance coverage which is to be placed inforce is subject to all of the provisions of the policy. Employer agrees to be bound by all of the terms, provisions and limitations of the policy and this application.

The employer also agrees that:

- Participation in the trust is subject to written approval of this employer application by Insurer or its designee; no liability is created for, or assumed by the trust or the insurer until this application has been approved in writing; acceptance of the check submitted with the application does not constitute approval or guarantee of insurance coverage; and if for any reason this application is not so approved in writing, the sole obligation of the trust and Insurer will be, and the employer shall be entitled to only a refund of any monies paid.
- The first premium payment is due as of the date coverage becomes effective; subsequent premiums are due on the first day of each succeeding month; a grace period of 31 days will be allowed for the payment of any premium due after the initial premium.
- The initial premium rates will remain in effect for the first six months of coverage, unless the employer elected the 12-month rate guarantee on the employer Application. The initial premium rate may change during the rate guarantee period if 1) the employer adds or deletes employees; 2) existing employees move to a higher age bracket; 3) employer moves to another geographic area; 4) employer modifies the plan's benefits; 5) the provider network fees change; 6) benefits change due to state or federal benefit mandates; or 7) any benefit changes occur during the period.
- Benefits under the policy begin on the employer's effective date and coverage ends as of the last day for which premium has been paid; and Insurer will not be liable for any health care claims incurred by any insured person after the date on which coverage has terminated.
- It will reimburse Insurer for any claims paid by Insurer for covered charges that are incurred by an employee after the date coverage under the policy is terminated.
- The Group Master Policy contains precertification requirements and an insured person's failure to comply with the precertification requirements may result in a reduction of benefits that may be payable under the terms of the policy.
- Coverage under the policy is available for U.S. residents only; employees must be legal U.S. residents and benefits are not payable for medical expenses for services received outside of the United States except for emergency care when traveling.
- It has reviewed all of the answers to the questions on this employer application; understands that it is employer's responsibility to provide truthful, complete and accurate information; represents that all of the information contained herein is true and complete; acknowledges that any material misstatements or failure to report information by employer or employees may be used as the basis of rescission or termination of employer's or any employee's coverage.
- Its agent is an independent insurance agent representing the employer, not the Insurer, and that no agent is authorized or has authority to 1) alter the terms of the policy or the trust; 2) waive, alter or modify any questions on this employer application; or 3) permit employer or employees to inaccurately answer any questions.
- All eligible employees are encouraged to apply for coverage during the employer's initial enrollment period, including those who may not be eligible for coverage yet because they are still in the "waiting period," and employer may only waive the "waiting period" for employees when the employer's coverage first becomes effective.
- It must maintain the minimum participation requirements stated herein; Insurer may periodically request and inspect payroll and personnel records to verify employee participation rates; employer will provide any such information that is requested; employer's failure or refusal to provide such information is grounds for termination of coverage; and employer's failure to maintain minimum participation requirements may result in coverage termination or loss of protection under the Health Insurance Portability and Accountability Act.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

[Arkansas Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

[Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.]

[Virginia Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

I acknowledge I am advised not to terminate any existing health or dental coverage plans until my agent receives notification that this application has been approved by Standard Security Life Insurance Company of New York.

Name of Owner or Officer - Print	Title
X Signature of Owner or Officer	Date

J. Agent Information and Statement

Name		IHC number	
Street address	City	State	ZIP code
E-mail address		Telephone number	

I certify that all of the information contained in this employer application and any attached papers is correct to the best of my knowledge. I have complied with all of the underwriting rules and have explained the coverage fully.

X _____ _____

Signature of primary writing agent Date

[If application is to be split, provide the secondary agent's information.

Secondary agent name		IHC number	
Street address	City	State	ZIP code
E-mail address		Telephone number	
Primary agent commission percentage		Secondary agent commission percentage	

I certify that all of the information contained in this employer application and any attached papers is correct to the best of my knowledge. I have complied with all of the underwriting rules and have explained the coverage fully.

X _____ _____

Signature of secondary writing agent Date]

K. Submission Checklist

- ❑ [Fully completed, signed and dated employer application.
- ❑ Fully completed, signed and dated employee Enrollment forms, which includes a section for those waiving coverage, for every eligible employee including those on or electing coverage through COBRA.
- ❑ Fully completed Multiple Unit Security Trust enrollment form.
- ❑ A premium proposal signed and dated by the employer or company representative.
- ❑ A business check, made payable to [IHC Health Solutions].
- ❑ A copy of the prior carrier's most recent billing statement, if replacing coverage.
- ❑ A copy of the employer group's wage and tax form or payroll records. Additional records may be requested to verify participation requirements have been met].

Additional forms may be required at enrollment or any time while coverage is inforce to support the initial underwriting process or to verify that the participation requirements are maintained.

SERFF Tracking Number:	*ICCI-126586603*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45896*
Company Tracking Number:	*SSL APP 0210*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*SSL EEAPP 0210 and ERAPP 0210*		
Project Name/Number:	*SSL EEAPP 0210 and ERAPP 0210/SSL EEAPP 0210 and ERAPP 0210*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	06/16/2010

Comments:

Attachment:

Cert of Comp. with Rule 19 SSL EE and ERAPP 0210.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	06/16/2010

Comments:

See Form Schedule tab.

		Item Status:	Status Date:
Satisfied - Item:	SSL Authorization Letter	Approved-Closed	06/16/2010

Comments:

Attachment:

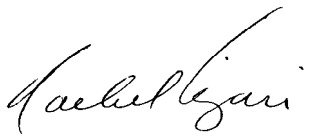
ICC Authorization letter SSL 2010.pdf

Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: Madison National Life Insurance Company, Inc.

Form Number(s): SSL EEAPP AR 0210
SSL ERAPP 0210

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.



Signature of Company Officer

Rachel Lipari

Name

President
Title

June 8, 2010
Date

STANDARD SECURITY
Life Insurance Company of New York

January 1, 2010

Mr. Brian Camling
President
Insurance Compliance Consultants, Inc.
3925 East State Street, Suite 200
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc., has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of Standard Security Life Insurance Company of New York regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Standard Security may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

Rachel Lipari